

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL VALLEY LEE c. LENGTH OF STAY IN 1b 22 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL VALLEY LEE d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First EARL Middle BARNES Last BARNES			4. DATE OF DEATH Month DECEMBER Day 3 Year 1965						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 24, 1903		9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAWER			10b. KIND OF BUSINESS OR INDUSTRY SAW MILL			11. BIRTHPLACE (County & State, or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS BARNES					14. MOTHER'S MAIDEN NAME MARY ?/?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 220-16-2120		17. INFORMANT FLOSSIE BARNES			Address VALLEY LEE, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic gangrene both feet									INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 years 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (i) (this hospital) attended the deceased from May , 1957, to Dec 2, 1965 , that (i) (we) last saw the deceased alive on Dec 1 1965, and that death occurred at 8A M, from the causes and on the date stated above.									
22a. SIGNATURE P. J. BEAN								22b. DATE SIGNED 12-3-65	
22c. PHYSICIAN'S NAME (Type) P. J. BEAN M. D.			22d. ADDRESS GREAT MILLS, MARYLAND		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF Dec. 5, 1965		23c. NAME OF CEMETERY OR CREMATORY ST. ANDREWS CEMETERY		23d. LOCATION (City, town or county) (State) LEONARDTOWN, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY					ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DEC 6 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ABELL ST. PATRICKS CREEK		c. LENGTH OF STAY IN 1b ABELL	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS DEWEY BLACKSTONE		4. DATE OF DEATH Month Day Year DECEMBER 23, 1965	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1900
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) COLTON POINT MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY BLACKSTONE		14. MOTHER'S MAIDEN NAME MYRTLE COOK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-12-2850	
17. INFORMANT MARY LILLIAN BLACKSTONE		Address ABELL, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) drowning DUE TO (b) 2 DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy		INTERVAL BETWEEN ONSET AND DEATH immed	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell over board while oystering	
20c. TIME OF INJURY Month, Day, Year Hour 11:00 a.m. 12-23-65 p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Patricks Creek	20f. (City or town) (County) (State) Abell St. Marys Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D Boyd		22. DATE SIGNED 12/24/65	
EXAMINER'S NAME (Type) WILLIAM D BOYD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/27/65	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART	23d. LOCATION (City, town or county) (State) BUSHWOOD, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DEC 28 1965 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20588

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charlotte Hall c. LENGTH OF STAY IN tb Charlotte Hall d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Jack Mattingly Lumber Co.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlotte Hall d. STREET ADDRESS Charlotte Hall, Md.	
3. NAME OF DECEASED (Type or print) WAYMAN First Middle Last CAIN 4. DATE OF DEATH Month 12 Day 23 Year 19 65		5. SEX male 6. COLOR OR RACE negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (in years last birthday) 35? yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 5810 DUE TO Fatty metamorphosis of the liver Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Rudiger Breiteneker</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-5-66 Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 13 '66	
22c. NAME OF CEMETERY OR CREMATION		22d. LOCATION (City, town, or country) (State) Baltimore Md	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR JAN 14 1966 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10116

July 11, 1943

W. A. R. 10116

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16944

20325

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEMENTS			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL CLEMENTS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD MAURICE CARTER				4. DATE OF DEATH Month Day Year DECEMBER 28, 19 65			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 21, 1965	
9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months Days 2 5		IF UNDER 24 HRS. Hours Min. 48			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Franklin				14. MOTHER'S MAIDEN NAME GRACE ELIZABETH CARTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address MOTHER SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 48 HRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William D. Boyd M.D.				22. DATE SIGNED 12/28/65			
EXAMINER'S NAME (Type) WILLIAM D. BOYD, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/29/65		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City or Town) (County) (State) BUSHWOOD ST. MARY'S MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				25a. REC'D BY REGISTRAR LEONARDTOWN, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chapters 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural c. LENGTH OF STAY IN 1b 9HRS 55 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, Patuxent River						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Great Mills d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Sigrid Middle Birgitta Last Cobb						4. DATE OF DEATH Month December Day 7 Year 19 65					
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 7, 65		9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months 9 Days 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Saint Mary's Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Stanley Milton Cobb						14. MOTHER'S MAIDEN NAME Elizabeth S. Rydeberg					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NA		17. INFORMANT Stanley M Cobb		Address Greenview Knolls, Great Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Anoxia 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cardio-respiratory failure (c) Prematurity										INTERVAL BETWEEN ONSET AND DEATH 9 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7 December 19 65 to 7 December 19 65 , that (I) (we) last saw the deceased alive on 7 December 19 65 , and that death occurred at 9:52P from the causes and on the date stated above.											
22a. SIGNATURE John P. Cloherty M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7 Dec 1965			
22c. PHYSICIAN'S NAME (Type) J. P. CLOHERTY LT MC USN						22d. ADDRESS Sta Hosp Pax Riv Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 12/10/65		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.			23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA			
24. FUNERAL DIRECTOR'S SIGNATURE P. S. Robinson ADDRESS LEONARDTOWN, MARYLAND						25a. REC'D BY REGISTRAR DEC 9 1965		25b. REGISTRAR'S SIGNATURE Charles Judge			

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John D. Wright

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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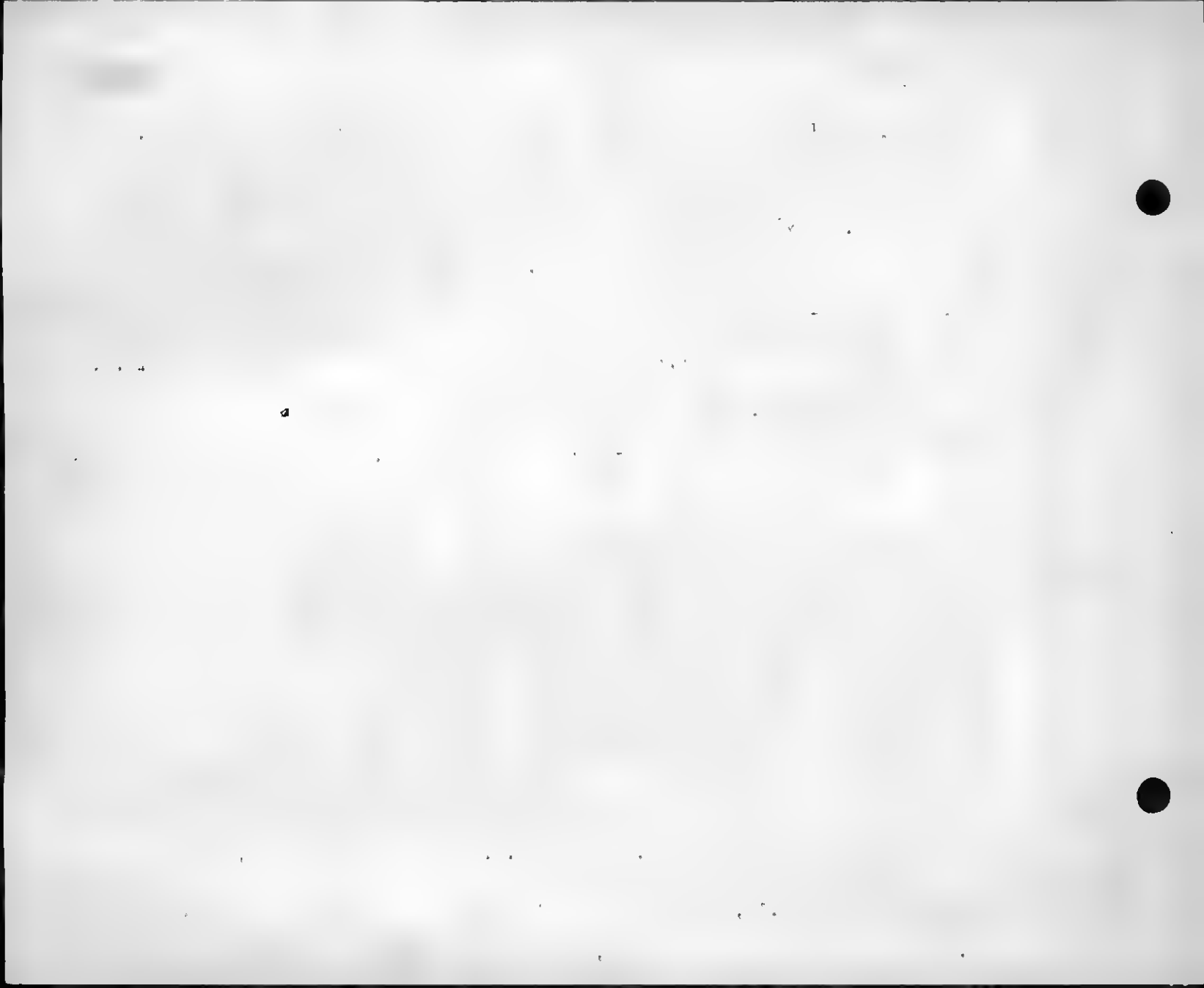
CERTIFICATE OF DEATH

2-227

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 17 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS CHURCH	
3. NAME OF DECEASED (Type or print) GEORGE PATRICK S. COMBS		4. DATE OF DEATH DECEMBER 16, 19 65	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ARCH 17, 1904
9. AGE (in years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK J. COMBS		14. MOTHER'S MAIDEN NAME SUSIE ABELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW2		16. SOCIAL SECURITY NO. 219-05-1152	
17. INFORMANT BERNARDINE G. COMBS		Address LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure + Coma 092X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infectious Hepatitis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 36 hrs 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____ and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John F. Fenwick		22b. DATE SIGNED 12-17-65	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 18, 1965	23c. NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL	23d. LOCATION (City or Town) (County) (State) MEDLEYS NECK, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. REC'D BY REGISTRAR DEC 22 1965	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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211 M 1/66

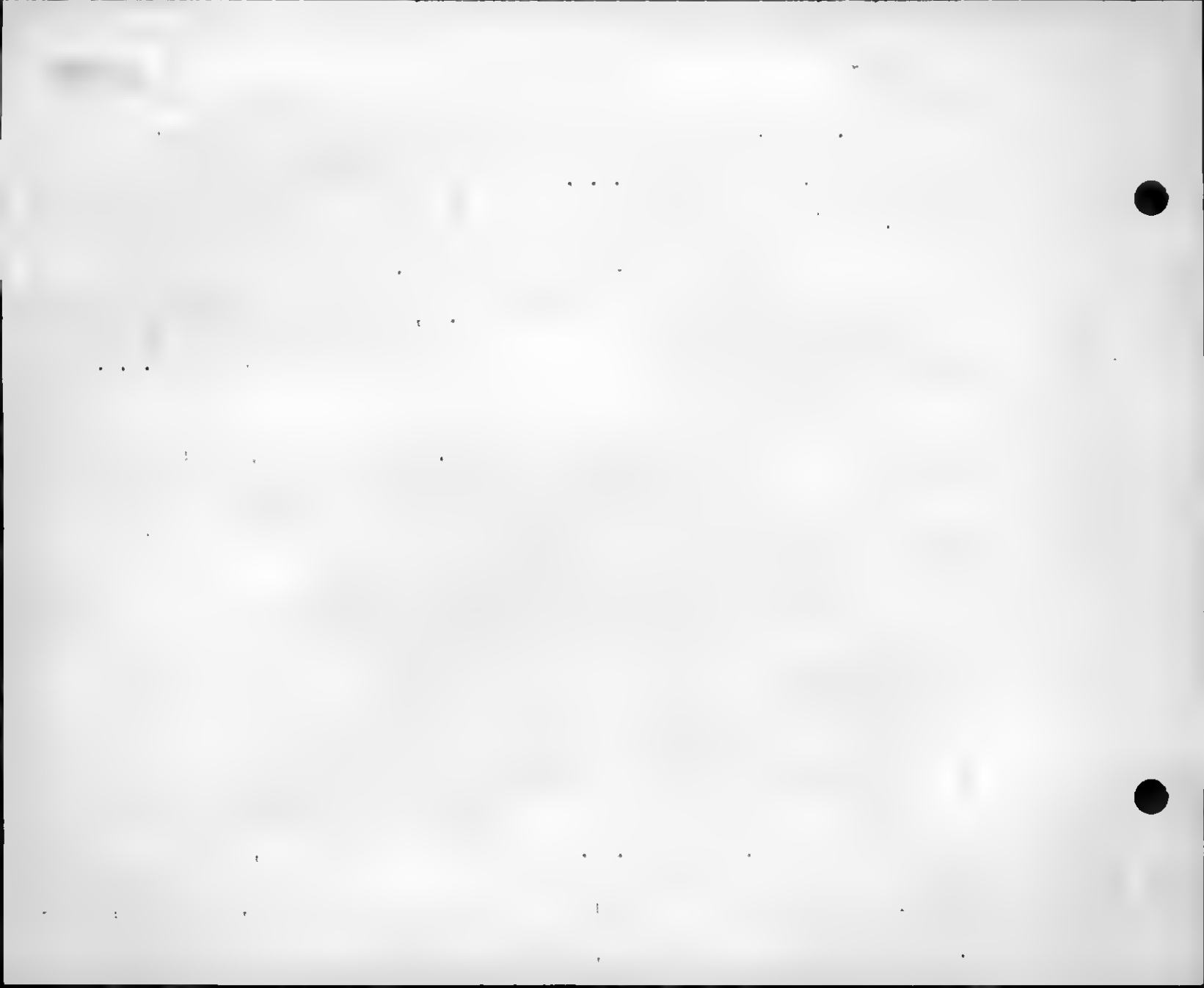
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16947

CERTIFICATE OF DEATH

21225

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EDWARD Last DIXON SR.		4. DATE OF DEATH Month DECEMBER Day 21 Year 19 65	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1876
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ?		14. MOTHER'S MAIDEN NAME ? ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO NONE	
17. INFORMANT HERMAN W. DIXON		Address ABELL, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John F. Fenwick		22b. DATE SIGNED 12-22-65	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/23/65	23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL GARDENS	23d. LOCATION (City or Town) (County) (State) WALDORF, CHARLES, Md.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DEC 27 1965	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

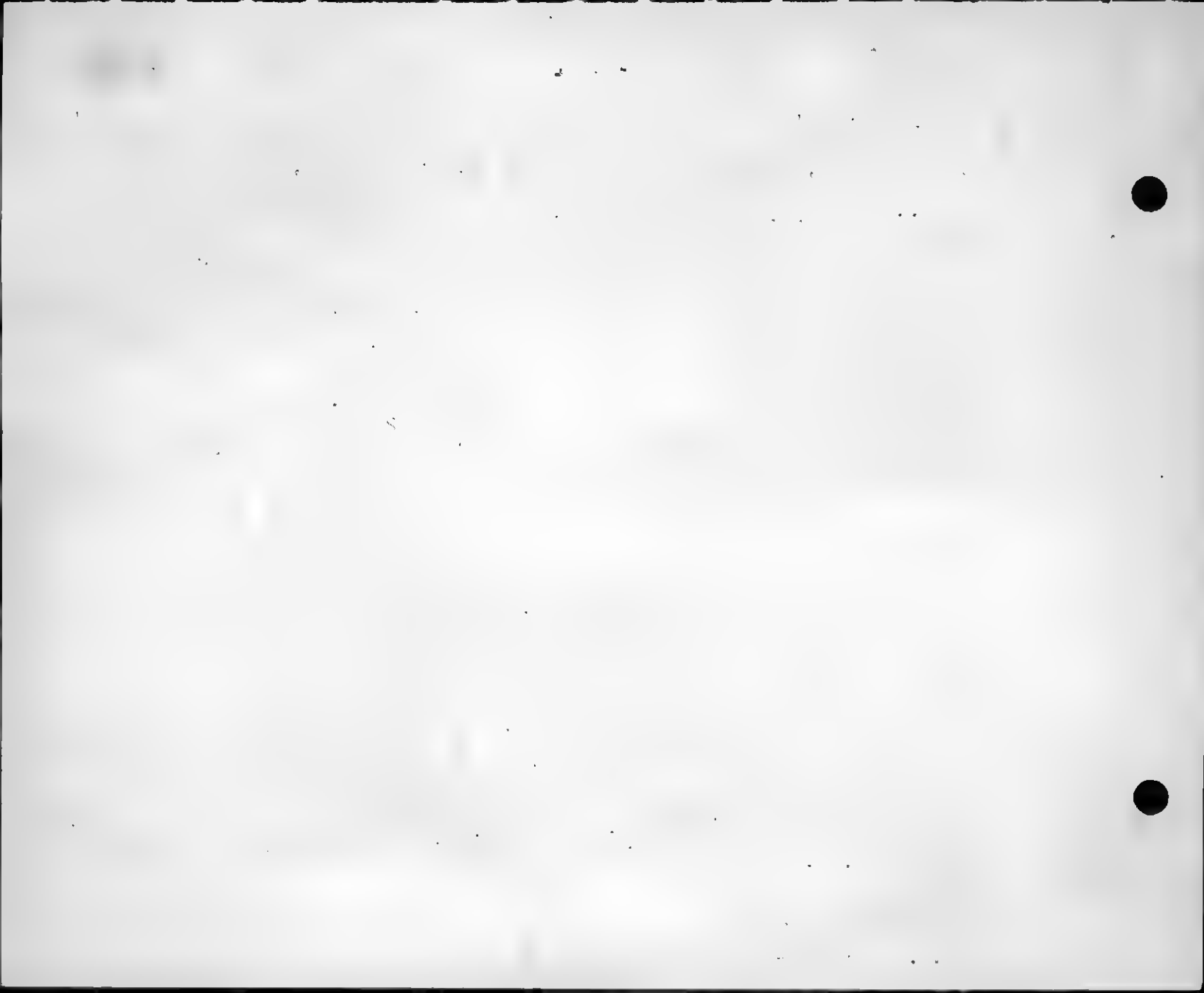
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16948

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River, Maryland				c. LENGTH OF STAY IN 1b Lexington Park, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNAS PAX RIV MD				g. STREET ADDRESS 62 Salamaua Court			
3. NAME OF DECEASED (Type or print) First Middle Last John Douglas Fenton				4. DATE OF DEATH Month Day Year December 14 1965			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1965		9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 17	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Don Joseph Fenton				14. MOTHER'S MAIDEN NAME Virginia E. Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT 63 Salamaua Court Father Lexington Park, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration 9210 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated vomitus					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:15 p.m. 12-14 1965		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Lexington Park St Marys Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. L. Marcus		EXAMINER'S NAME (Type) E. L. MARCUS, LT MC USNR		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 12-15-65	
23a. BURIAL CREMATION, REMOVAL (Specify) Transit		23b. DATE THEREOF 12/15/65		23c. NAME OF CEMETERY OR CREMATORY Jasper, Alabama		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Maryland				25a. REC'D BY REGISTRAR DEC 17 1965			

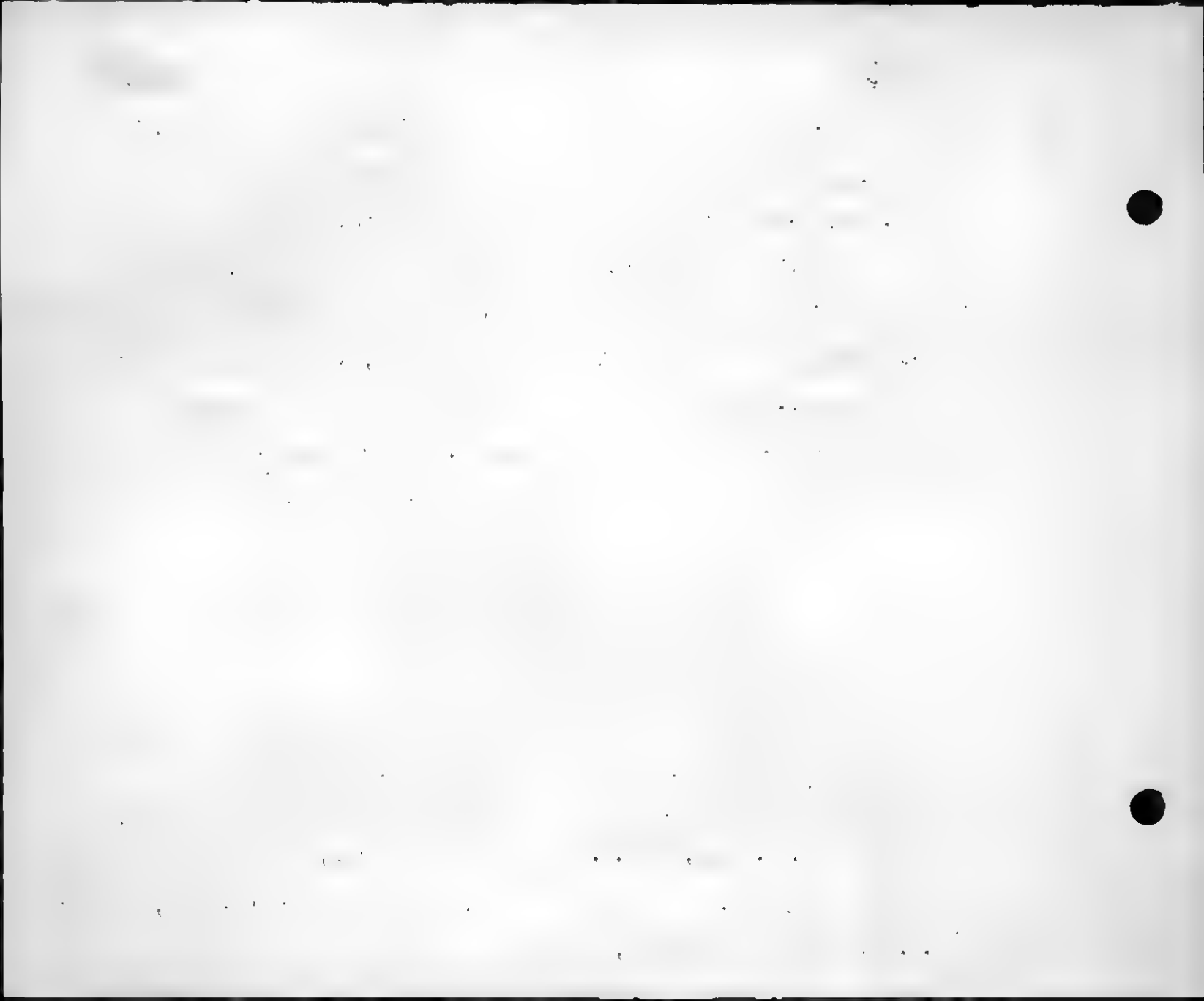


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN lb St. Marys Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaptico d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAY REEDER FOWLER		4. DATE OF DEATH Month Day Year December 27 19 65	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 / 30 / 1891
9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Domestic	
12. BIRTHPLACE (County & State, or foreign country) Morganza, Maryland		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME John H. Reeder		15. MOTHER'S MAIDEN NAME Mary Dallam	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		17. SOCIAL SECURITY NO. Zack M. Fowler - same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction DUE TO (b) 4:1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH immed	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 65 , to 12-27 , 19 65 , that (I) (we) last saw the deceased alive on 12-26 , 19 65 , and that death occurred at 1245 M, from the causes and on the date stated above.			
22a. SIGNATURE Wm. D. Boyd		22b. DATE SIGNED 12/27/65	
22c. PHYSICIAN'S NAME (Type) Wm. D. Boyd, M.D.		22d. ADDRESS Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/30/65	23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery	23d. LOCATION (City, town or county) (State) Charlotte Hall, Maryland
24. FUNERAL DIRECTOR P.B. Robinson		25a. REC'D BY REGISTRAR DEC 29 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16950

CERTIFICATE OF DEATH

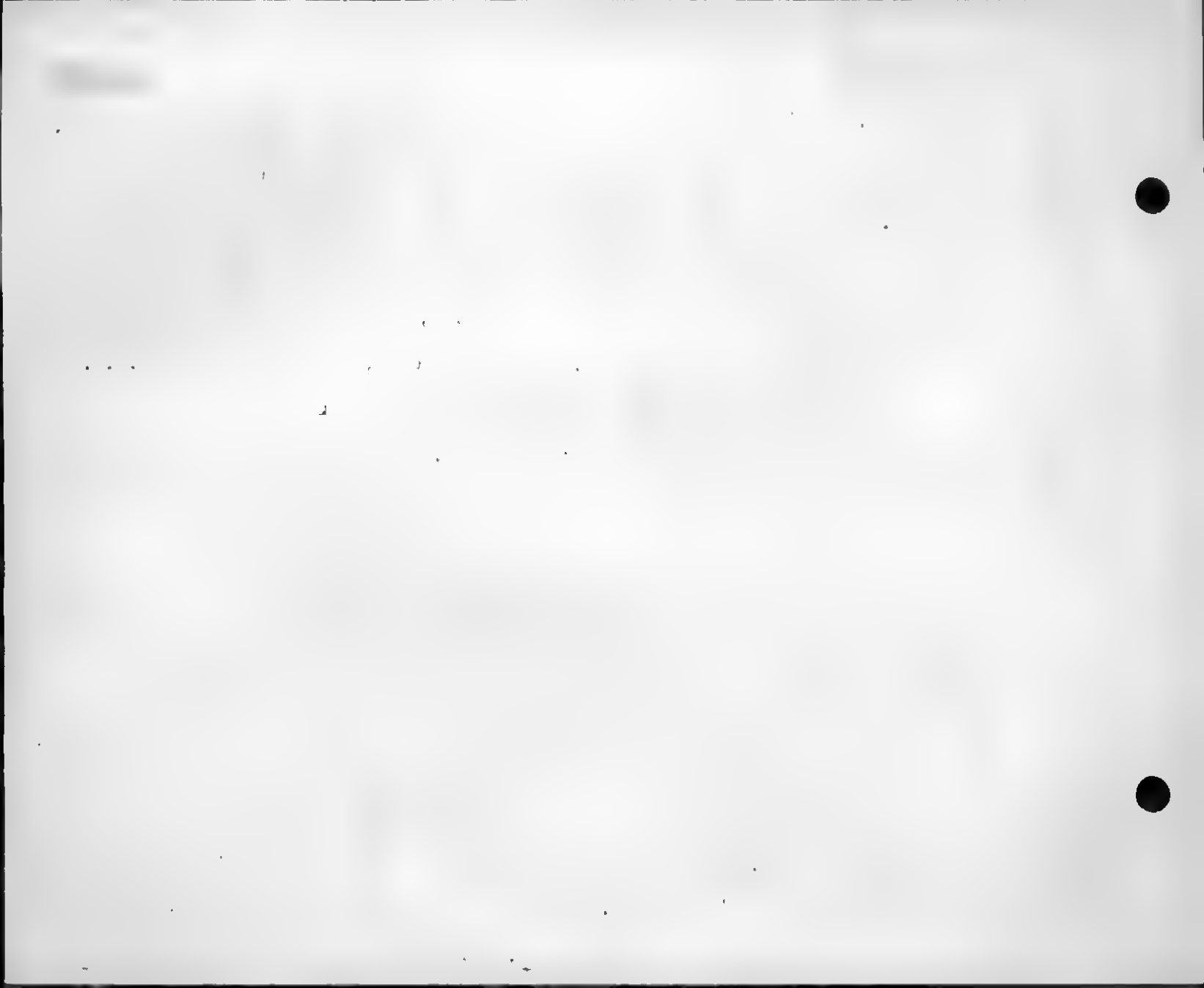
21231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,		c. LENGTH OF STAY in 1b 7 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS MECHANICSVILLE	
3. NAME OF DECEASED (Type or print) First HAROLD Middle GREENWELL Last GRAVES		4. DATE OF DEATH Month DECEMBER Day 16 Year 1965	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 6, 1905
9. AGE (In years last birthday) 60 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	11. BIRTHPLACE (County & State, or foreign country) MARYLAND, MECHANICSVILLE U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ZACHARICK SAMSON GRAVES	
14. MOTHER'S MAIDEN NAME JANE ELIZABETH BISCOE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES	
16. SOCIAL SECURITY NO. 217-36-6337		17. INFORMANT EDNA B. GRAVES Address MECHANICSVILLE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neurosarcoma - 20 yrs nerve 1939 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1955 , to Dec 16, 1965 ; that (I) (we) last saw the deceased alive on Dec 14 1965 , and that death occurred at 3 A M, from causes on and on the date stated above.			
22a. SIGNATURE J Roy Luythor		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J Roy Luythor		22d. ADDRESS MECHANICSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/18/65	23c. NAME OF CEMETERY OR CREMATORY MT. ZION	23d. LOCATION (City or Town) (County) (State) LAUREL GROVE, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY ADDRESS LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR DEC 22 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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20 M 1/66



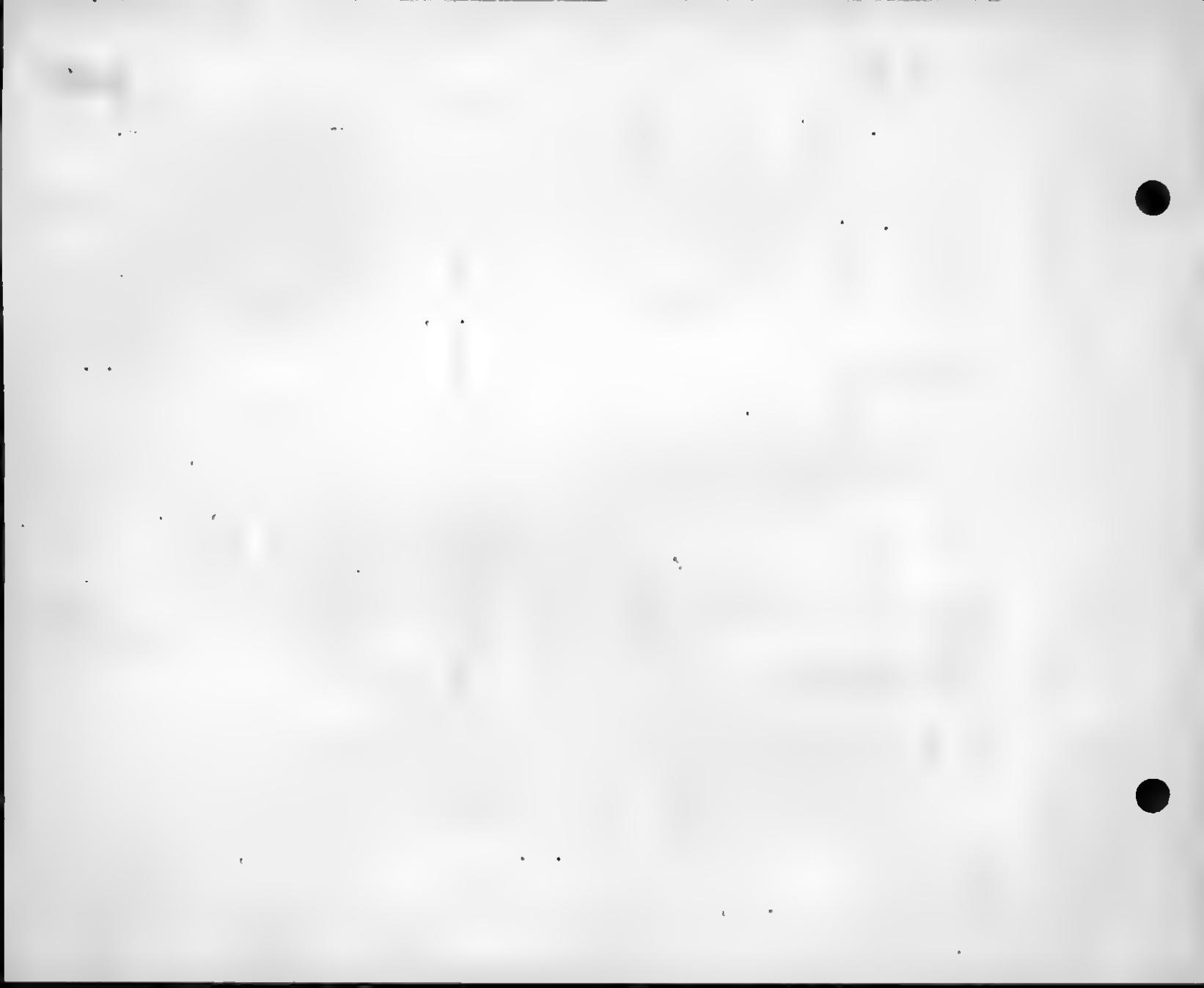
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16951

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM MARSHALL HALL		4. DATE OF DEATH Month Day Year DECEMBER 22, 19 65	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7, 1887
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WASHINGTON HALL		14. MOTHER'S MAIDEN NAME BETTY ELIZABETH NEVITT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS AGNES M. DOWNS		Address AVENUE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO (b) Pneumonia DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH hrs days yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) yes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/22/65 to 12/22/65 , that (I) was last saw the deceased alive on 12/22/65 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE J. PATRICK JARBOE M.D.		22b. DATES SIGNED 12/24/65	
22c. PHYSICIAN'S NAME (Type) J. PATRICK JARBOE M.D.		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 24, 1965	
23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. REG'D BY REGISTRAR DEC 28 1965	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

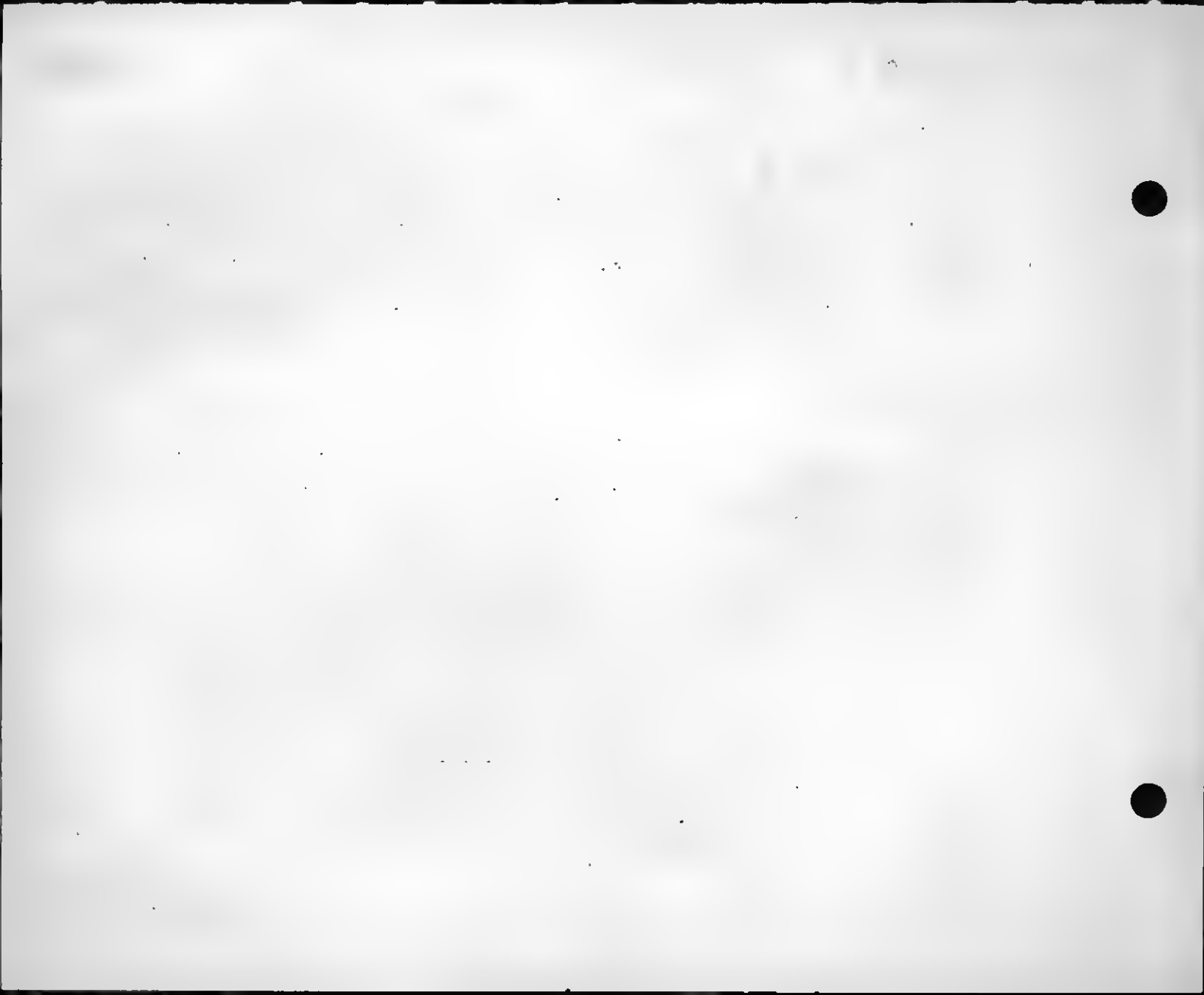
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FOR STATE
HEALTH DEPT.

16952

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21333

1. PLACE OF DEATH a. COUNTY St. Mary's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson		c. LENGTH OF STAY IN 1b MAYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. STREET ADDRESS Route 2		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NORMAN A. HENDERSON		4. DATE OF DEATH Month Day Year December 26 19 65		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1935	
9. AGE (in years last birthday) 30 yrs.		10. BIRTHPLACE (State or foreign country) North Carolina		11. CITIZEN OF WHAT COUNTRY? USA	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction		13. FATHER'S NAME Norman Henderson	
14. MOTHER'S MAIDEN NAME Lousia Dail		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Louisa Henderson Rt. 2 Wallace, N.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration complicating fatty infiltration of the liver 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-27-65	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-65		23c. NAME OF CEMETERY OR CREMATORY Henderson Family Cemetery	
24. FUNERAL DIRECTOR Ullrich Funeral Home Balto., Md.,		23d. LOCATION (City, town or county) (State) Dukeland Co., N.C.		25a. REC'D BY REGISTRAR DEC 29 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	



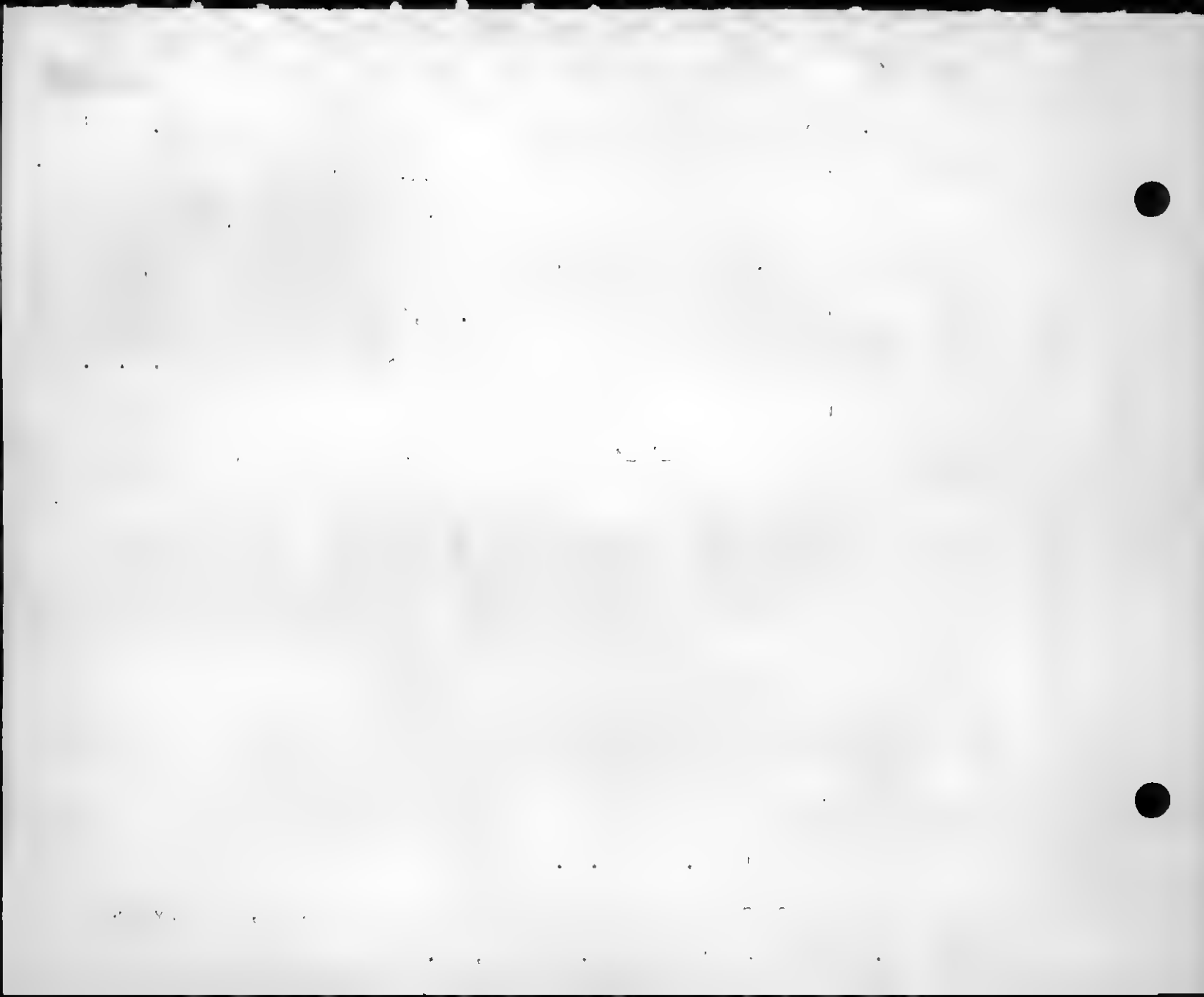
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16953

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MECHANICSVILLE d. STREET ADDRESS XXXXXXXXX CAPT ST. MARY'S e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHRISTE Middle KONSTANTINE Last HENES				4. DATE OF DEATH Month DECEMBER Day 23 Year 1965			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 24, 1894	
9. AGE (In years last birthday) 70 yrs.		10. UNDER 1 YEAR (Months) 70		11. UNDER 24 HRS. (Days) 70		12. UNDER 24 HRS. (Hours) 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREECE	
13. FATHER'S NAME KONSTANTINE HENES				14. MOTHER'S MAIDEN NAME ? ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 577-48-1608		17. INFORMANT MRS DEJANIRA HENES SAME AS # 2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH imposed			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W.D. Boyd				22. DATE SIGNED 12/23/65			
EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-27-65		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town or county) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR ROBERT E. WILHELM 4308 SUITLAND RD. SUITLAND, MD				25. REC'D BY REGISTRAR DEC 28 1965			
				25b. REGISTRAR'S SIGNATURE f Charles Judge			

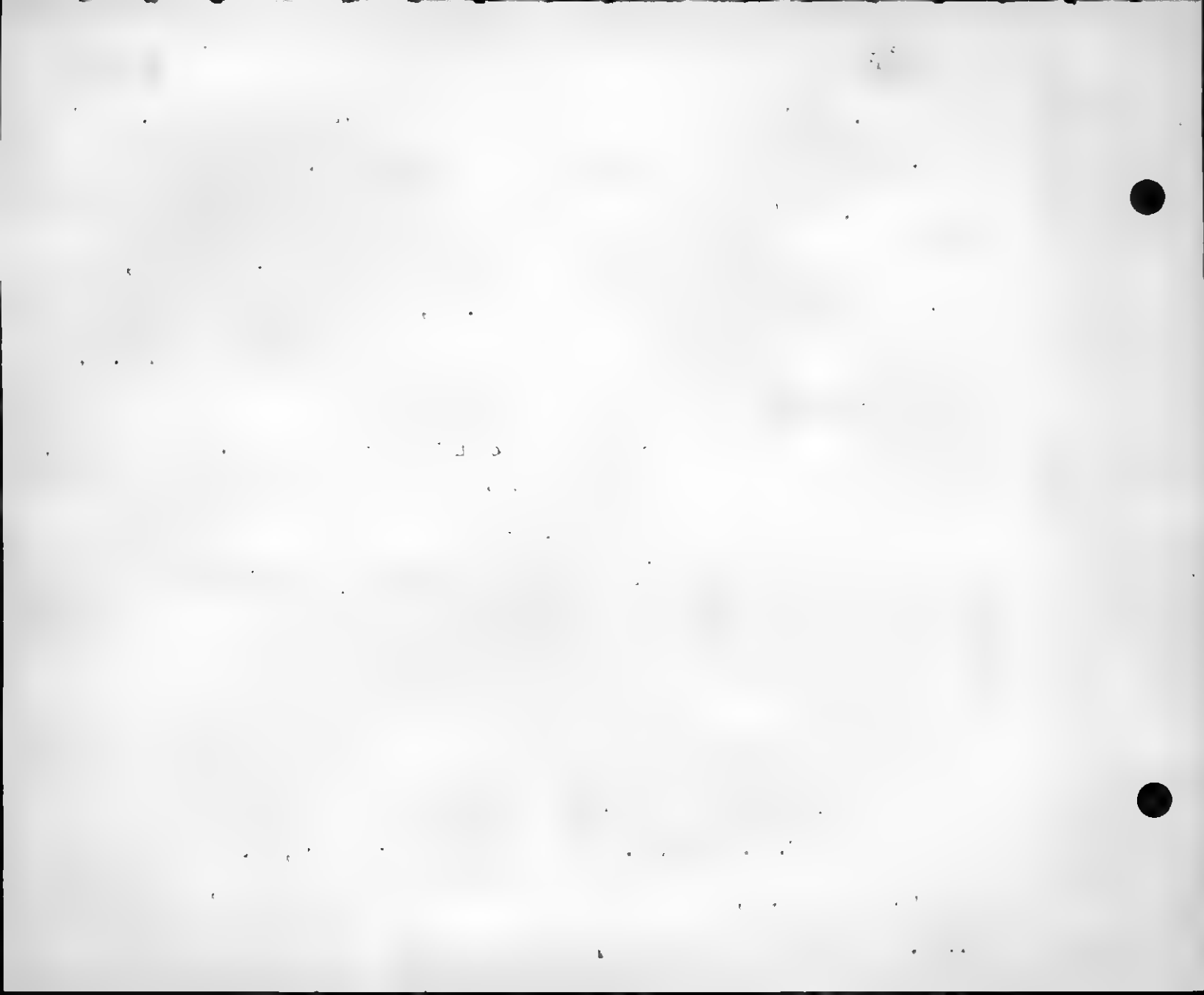


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL ST. GEORGE ISLAND d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First HAROLD Middle LELAND Last HUDSON			4. DATE OF DEATH Month DECEMBER Day 8 Year 1965		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH OCT. 20, 1898 9. AGE (In years last birthday) 67 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) VERMONT 12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME MARSHALL HUDSON					14. MOTHER'S MAIDEN NAME EMMA PEASE						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 009-09-2297 17. INFORMANT RACHEL SPRAGUE HUDSON Address ST. GEORGE ISLAND,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema MARYLAND (b) pneumothorax (c) pulmonary embolism, pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE <i>J. C. Roa M.D.</i>					22c. PHYSICIAN'S NAME (Type) J. C. ROA M. D.					22d. ADDRESS LEXINGTON PARK, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF DEC. 11, 1965		23c. NAME OF CEMETERY OR CREMATORY MEETING HOUSE ROAD CEMETERY		23d. LOCATION (City, town or county) (State) HINSDALE, NEW HAMPSHIRE				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR DEC 13 1965		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

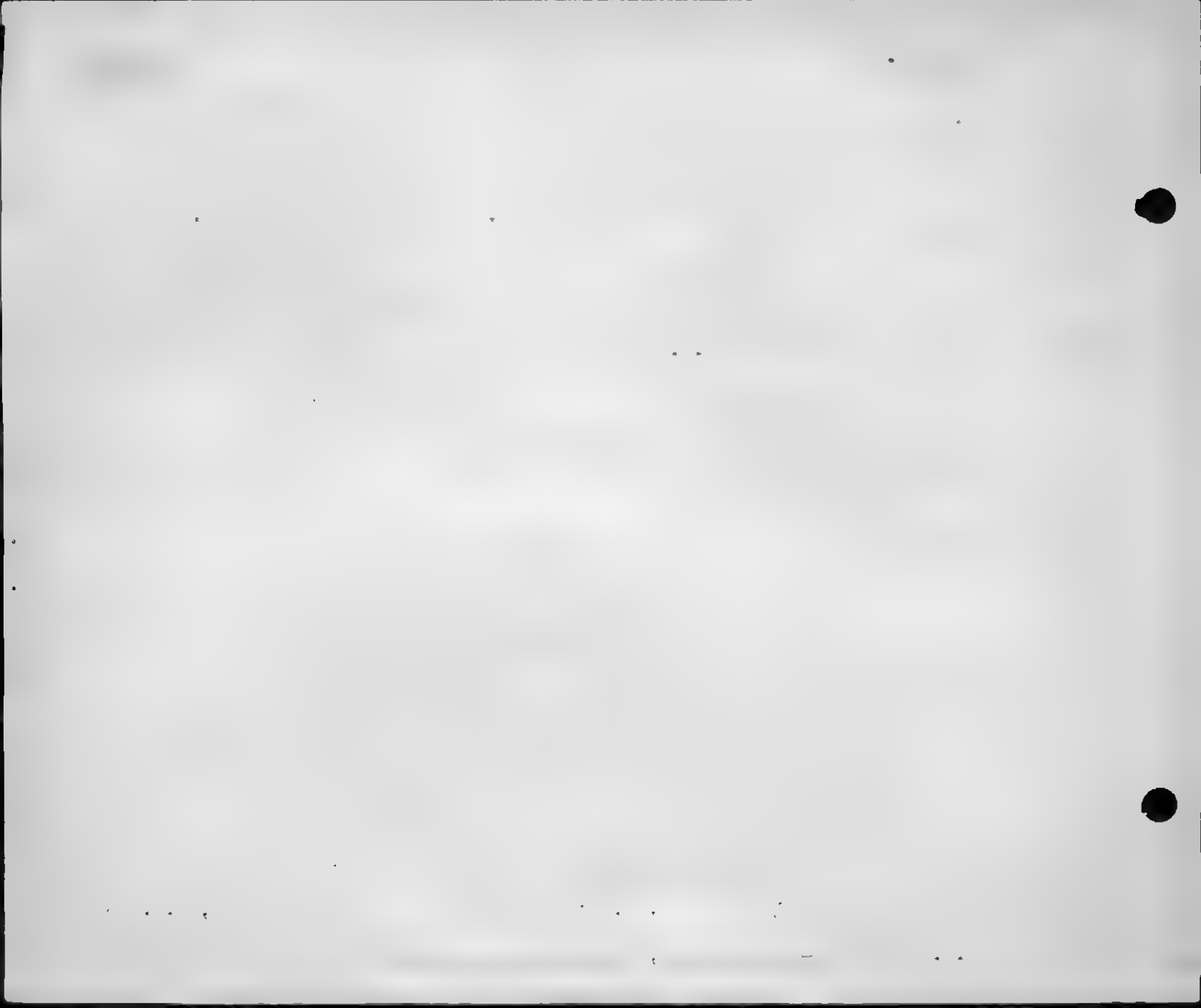
CERTIFICATE OF DEATH

16955

30

1. PLACE OF DEATH a. COUNTY St. Marys ¹ MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River, Md. 21 years c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, U.S. Naval Air Stat. Patuxent Beach, Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Marys ¹ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James William KELLY		4. DATE OF DEATH December 26 1965		5. SEX Male			
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1896			
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired)		11. BIRTHPLACE (County & State, or foreign country) West Virginia			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Kelly		14. MOTHER'S MAIDEN NAME Laveri Blackford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1917 to 1945		16. SOCIAL SECURITY NO. 213 54 7620		17. INFORMANT (Wife) Donna A. KELLY #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) Ischemic Heart Disease (a), stating the underlying cause last. (c) Chronic Obstructive Emphysema				INTERVAL BETWEEN ONSET AND DEATH 17 days 5-10 yrs. 5-10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 9 December, 1965 to 26 December 1965, that (I) (we) last saw the deceased alive on 23 December 1965, and that death occurred at 1:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE E. L. Marcus		22b. DATE SIGNED 26 December 65		22c. PHYSICIAN'S NAME (Type) E. L. MARCUS, LT MC USNR			
22d. ADDRESS Station Hospital, USAS Patuxent River, Maryland		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12/29/65		23c. NAME OF CEMETERY OR CREMATORY J.Wm. Lee Crematory			
23d. LOCATION (City, town or county) Washington, D.C.		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Maryland		24a. ADDRESS		25a. REC'D BY REGISTRAR DEC 29 1965			
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

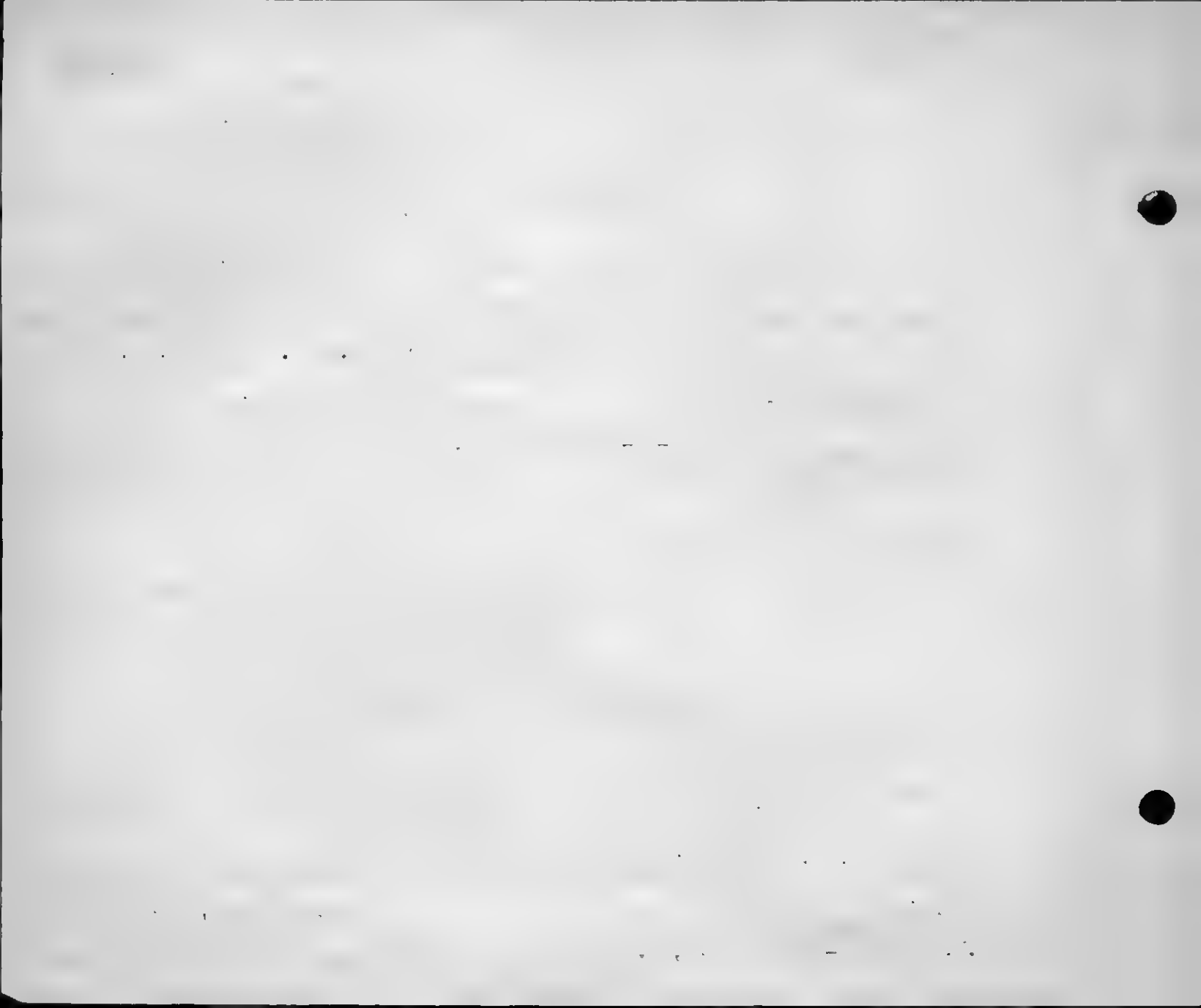
CERTIFICATE OF DEATH

16956

2033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Station Hospital, NAS, Patuxent River</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> d. STREET ADDRESS <u>Qtrs. P, MOQ</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u>		First <u>Elizabeth</u> Middle <u>Lizer</u> Last <u>Lizer</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1965</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>April 25, 1883</u>			
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stearns Co. MINN.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Benjamin Veeder</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Colthorp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>501-40-5329</u>		17. INFORMANT <u>Loren C. Whitney</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1965 to Dec. 29, 1965, that (I) (we) last saw the deceased alive on Dec. 29, 1965, and that death occurred at 10:55 M, from the causes and on the date stated above.							
22a. SIGNATURE <u>E. L. Marcus</u> M.D.		22b. DATE SIGNED <u>Dec 29, 1965</u>		22c. PHYSICIAN'S NAME (Type) <u>E. L. MARCUS, LT MC USN</u>			
22d. ADDRESS <u>Same as 1d</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>					
23b. DATE THEREOF <u>12/30/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Watford City, North Dakota</u>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL HOME'S SIGNATURE <u>P.B. Robinson - Leonardtown, MD.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

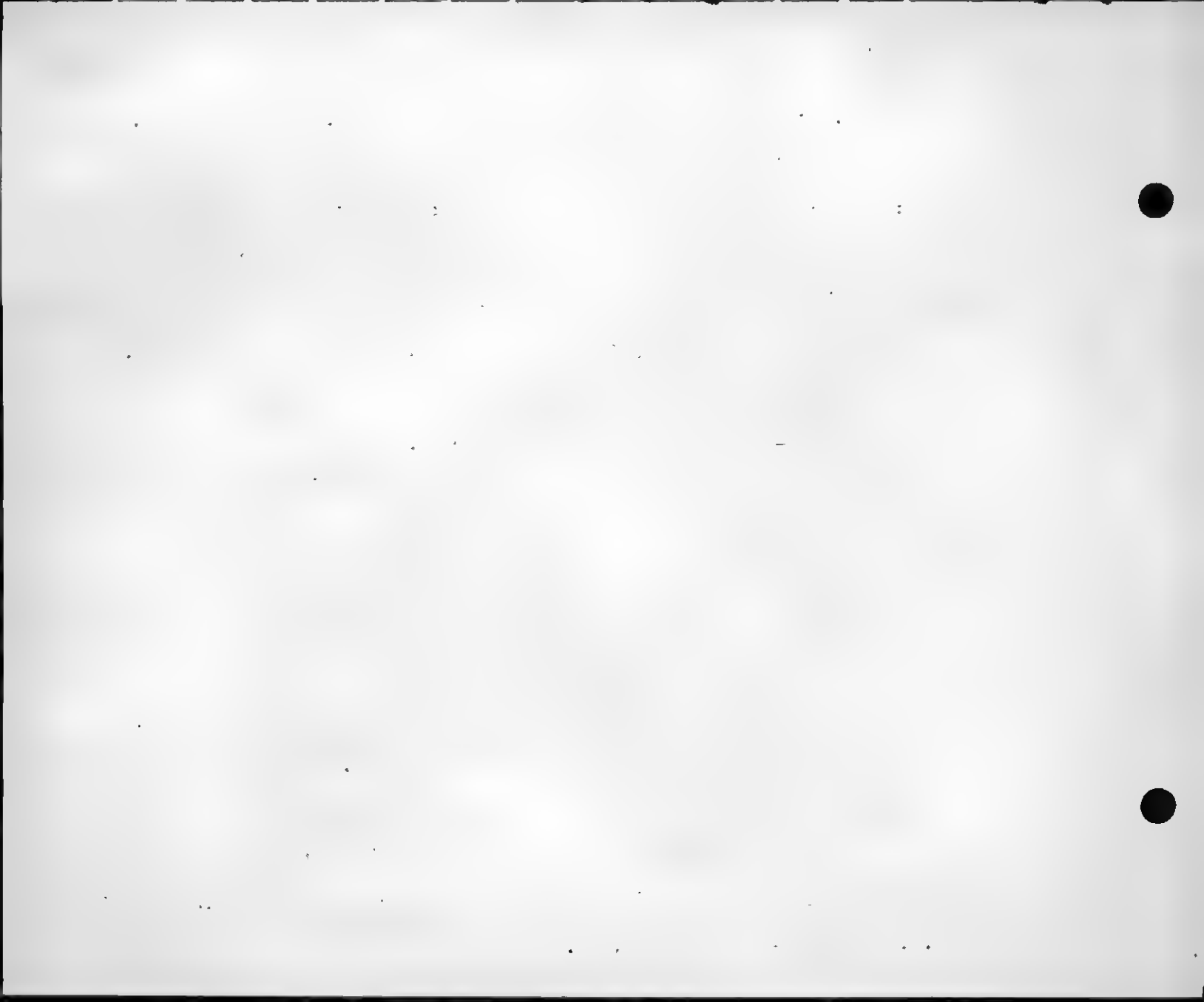
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16957

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - California</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>California</u>			
c. LENGTH OF STAY IN 1b <u>15 yrs</u>				d. STREET ADDRESS <u>Rt: # 2 Box 160</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt: #2 Box 160</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELSYE</u> Middle <u>JAMES</u> Last <u>NEWTON</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>19 65</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 / 26 / 1900</u>		9. AGE (in years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217 52 8205</u>		17. INFORMANT <u>Herbert A. Newton - same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Intestinal tract</u> <u>1539</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7th</u> , 19 <u>65</u> , to <u>Dec 9th</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 9th</u> , 19 <u>65</u> , and that death occurred at <u>8 p.m.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles Greenwell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/10/65</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Greenwell, MD</u>				22d. ADDRESS <u>Leonardtown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/13/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>P.B. Robinson - Leonardtown, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 15 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

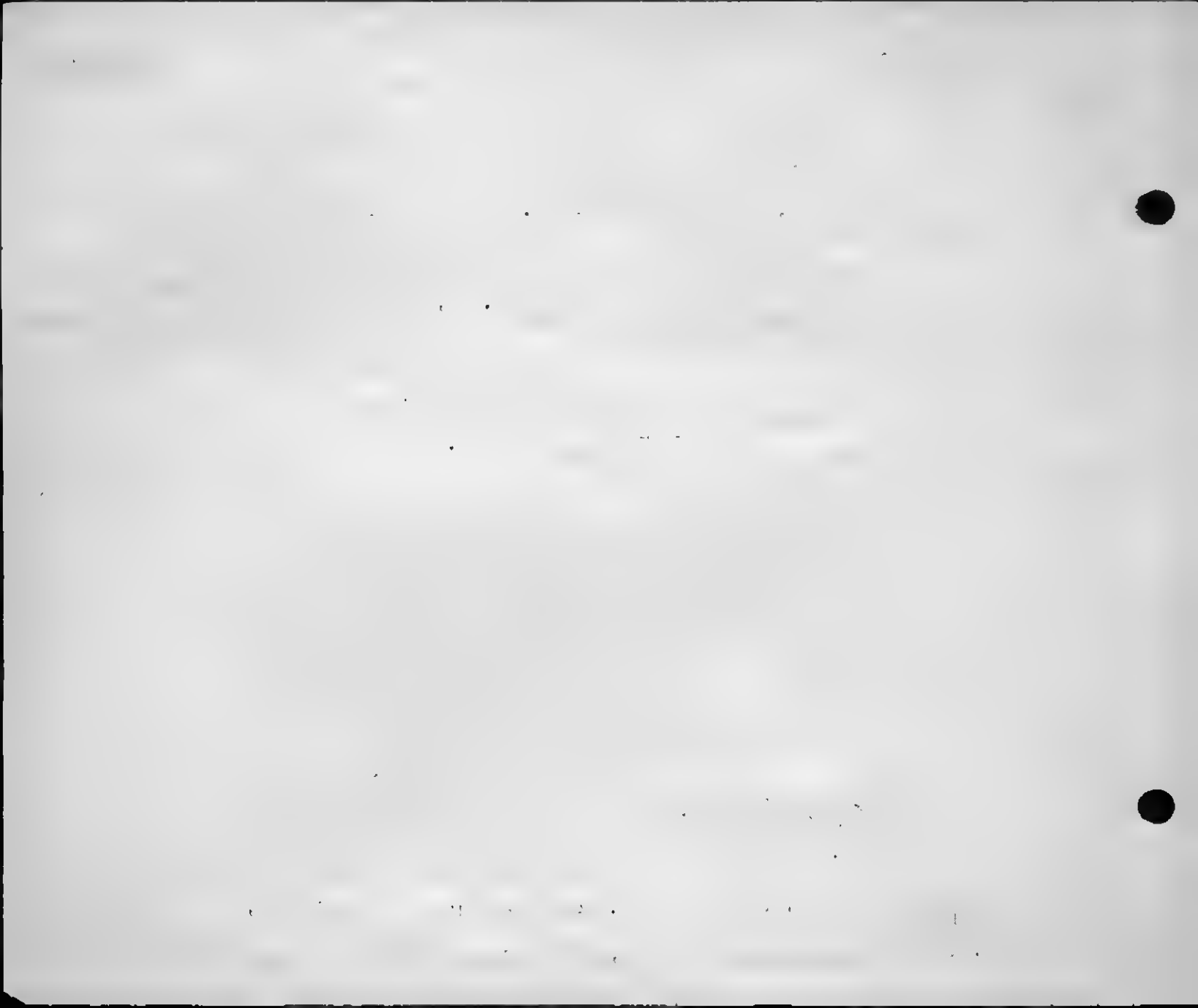


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

<div style="text-align: center;"> CERTIFICATE OF DEATH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16958 </div>													
1. PLACE OF DEATH a. COUNTY <u>Saint Mary's</u> <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Saint Mary's</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River, Maryland</u>				c. LENGTH OF STAY IN 1b <u>2 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Town Creek</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Station Hospital, Patuxent River, Md.</u>						d. STREET ADDRESS <u>107 Elm Court</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Eunice</u> Middle <u>Hynds</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1965</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 20, 1899</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New Haven Connecticut</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u> ? ? </u>						14. MOTHER'S MAIDEN NAME <u> ? ? </u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>036-24-8598</u>		17. INFORMANT <u>Peter T. Smith</u>				Address <u>107 Elm Court Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>3 DEC 1965</u> to <u>3 DEC 1965</u> , that (I) (we) last saw the deceased alive on <u>3 DEC 1965</u> , and that death occurred at <u>1:40</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Frank J. Konicek</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>					
22c. PHYSICIAN'S NAME (Type) <u>F. J. KONICEK LT MC USNR</u>						22d. ADDRESS <u>3ta Hosp Patux Riv Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>Dec. 4, 1965</u>		23c. NAME OF CEMETERY OR CREMATORY <u>XXXXXX CEDAR HILL</u>				23d. LOCATION (City, town or county) (State) <u>SUITLAND, MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. CLARKE MATTINGLEY</u>						ADDRESS <u>LEONARDTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

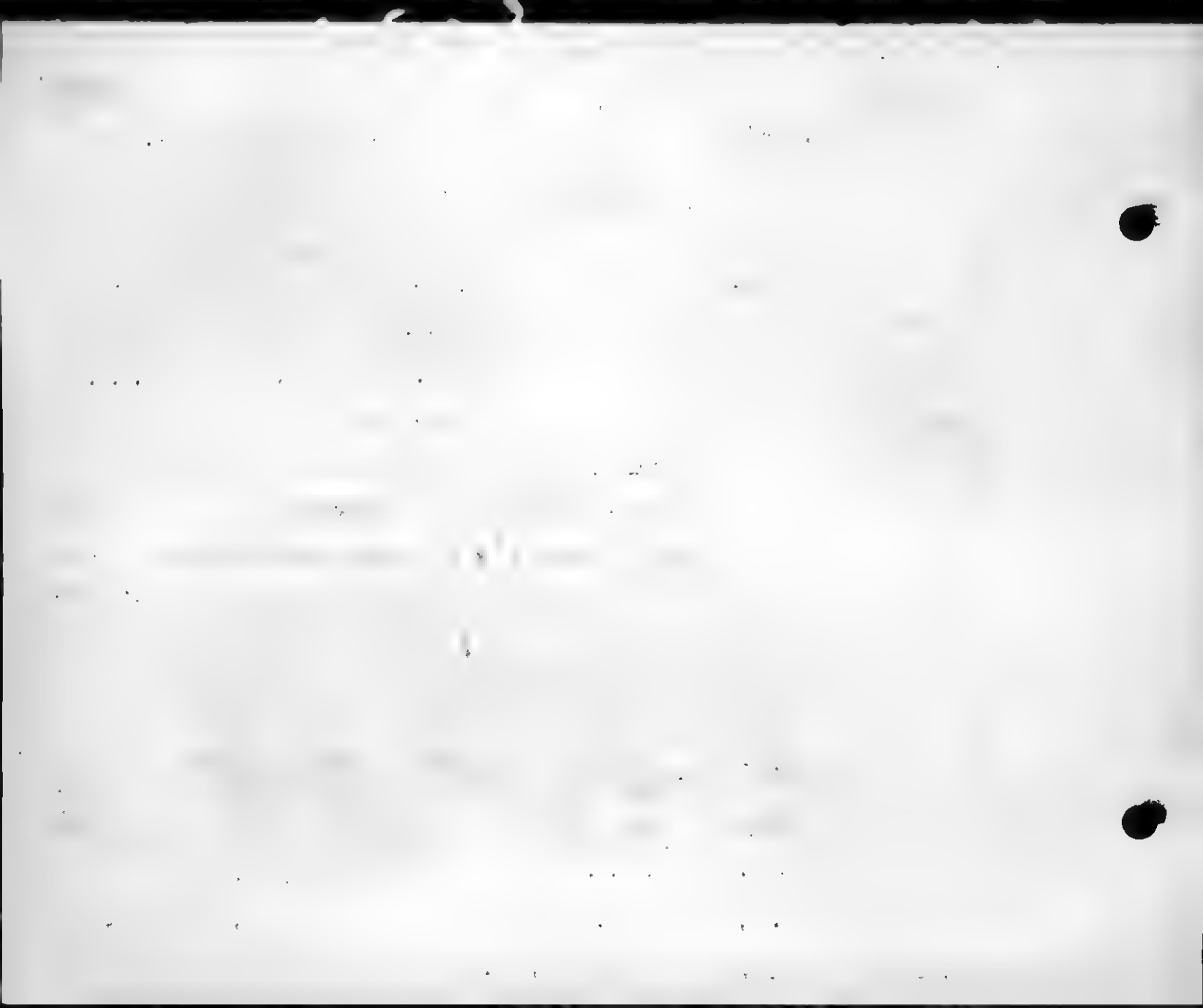
1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>SOMERVILLE</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>19 65</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE (In years last birthday) <u>38</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eddie Somerville</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Shade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218 24 7041</u>	
17. INFORMANT <u>Mary E. Bush</u>		Address <u>same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration</u> DUE TO (b) <u>acute alcoholism</u> DUE TO (c) <u>3hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>aspirated vomitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>aspirated vomitus</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 a.m. 12-12-1965</u>		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Starlite Club</u>		20f. (City or town) (County) (State) <u>Charlotte Hall St Marys Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm. D. Boyd</u>		22. DATE SIGNED <u>12-15-65</u>	
EXAMINER'S NAME (Type) <u>Wm. D. Boyd</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/16/65</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Charlotte Hall, Maryland</u>	
24. FUNERAL DIRECTOR <u>P.B. Robinson - Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 17 1965</u>	
		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as file burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16961

20349

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DRAYDEN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DRAYDEN d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SARAH Middle M. Last WHALEN			4. DATE OF DEATH Month DECEMBER Day 11 Year 1965				
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12, 1880	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME FRED EXX GLADDEN				
14. MOTHER'S MAIDEN NAME LETTIE YOUNG			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. NONE			17. INFORMANT ADELADE W. BROWN Address DRAYDEN, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 hours 1 1/2 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from May 1, 1960 to Dec 11, 1965 , that (I) (we) last saw the deceased alive on Dec 9, 1965 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE P. J. BEAN M. D.			22b. DATE SIGNED 12/12/65				
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS GREAT MILLS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 15, 1965		23c. NAME OF CEMETERY OR CREMATORY ST. MARKS CEMETERY			
23d. LOCATION (City, town or county) (State) VALLEY LEE, MARYLAND		24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DEC 22 1965			
25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16962 CERTIFICATE OF DEATH 20342									
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN ID 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL VALLEY LEE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DEBORAH Middle LYNN Last YOUNG					4. DATE OF DEATH Month DECEMBER Day 1 Year 1965				
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 16, 1965		9. AGE (In years last birthday) Months 4 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES L. MORGAN					14. MOTHER'S MAIDEN NAME REBECCA YOUNG				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER VALLEY LEE, MARYLAND			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Enterococci									INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 25, 1965 to Dec 1, 1965 , that (I) (we) last saw the deceased alive on Nov 30, 1965 , and that death occurred at 4 A.M. from the causes and on the date stated above.									
22a. SIGNATURE P.J. BEAN M.D.					22b. DATE SIGNED 12/2/65		22c. PHYSICIAN'S NAME (Type) P.J. BEAN M.D.		
22d. ADDRESS GREAT MILLS, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF DEC. 2, 1965		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE CEMETERY		23d. LOCATION (City, town or county) (State) VALLEY LEE, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY					25a. REC'D BY REGISTRAR DEC 6 1965		25b. REGISTRAR'S SIGNATURE Charles Judge		
ADDRESS LEONARDTOWN, MARYLAND									

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